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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G183	A. BUILDING _____ B. WING _____	10/31/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	4414-16 JAY STREET, NE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS	W 000		

A recertification survey was conducted from October 29, 2008 through October 31, 2008. The fundamental survey process was initiated however due to concerns in Client Protections and Active Treatment, the survey was extended in those areas.

A random sample of two clients was selected from a residential population of three females and one male with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews and a review of records, including unusual incident reports.

On October 29, 2008, a determination was made that staff's conduct towards Clients #2 and #3 during breakfast posed an immediate and serious threat to their health and safety. At 4:32 PM, the facility's Qualified Mental Retardation Professional (QMRP) and Program Director were notified that an immediate jeopardy existed. The surveyor remained on site until the facility addressed the immediate jeopardy by implementing the following plan to alleviate the identified concerns and protect the client's from further potential harm:

- the alleged abuser was placed on administrative leaving pending the outcome of an investigation;

- the two additional staff that witnessed the alleged abuse were placed on administrative leave pending the outcome of an investigation; and

- all remaining staff will be in-serviced by October 31, 2008 on abuse and neglect, incident

Received 12/5/08

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Luttie L. Moore	Director of Residential Services	12-5-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 reporting, mealtime protocols, and Client #2's Behavior Support Plan (BSP). As a result of the findings, a determination was made that the facility failed be in compliance with the Condition of Participation requirements in Client Protection.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, staff interviews, and record reviews the governing body failed to ensure that the facility exercised general policy, and operating direction over the facility. The findings include: 1. Cross Reference to W127. The governing body failed to ensure that systems were implemented to ensure clients were not subjected to verbal, physical, psychological abuse and mistreatment 2. Cross Refer to W153. The governing body failed to ensure that all injurious of unknown source were immediately reported to the administrator or to other officials in accordance with State law. 3. Cross Reference to W154. The governing body failed to provide evidence that all incidents involving injuries of unknown origin had been thoroughly investigated.	W 104	**Conditions Out** **12-2-08** **W104** **MTS has made the system corrections needed to address the issues that caused the Client Protections condition to be out of compliance as evidenced by the responses throughout and particularly, the responses for W127, W153, W154, W369 and W392.**	

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W 104	Continued From page 2 4. Cross Reference to W369. The governing body failed to ensure that clients received all prescribed medications without error. 5. Cross Reference to W392. The governing body failed to ensure that discontinued medications were removed from the clients current medication supply.	W 104		
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure entries into the clients records were signed for two of the two clients included in the sample. (Clients #1 and #3) The findings include: The facility's Registered Nurse (RN) failed to sign Clients #1 and #2's quarterly reviews. a. Interview with the facility's Registered Nurse on October 29, 2008 at approximately 3:00 PM revealed that she (RN) completed quarterly nursing examinations. Review of the Client #1's medical record revealed a nursing quarterly review dated October 22, 2008 that was not signed. b. Interview with the facility's Registered Nurse on October 30, 2008 at approximately 11:00 AM revealed that she (RN) completed quarterly nursing examinations. Review of the Client #2's medical record revealed a nursing quarterly review dated August 18, 2008 that was not	W 114	W114 The RN has placed a post-dated signature on the cited quarterly nursing examinations. There is an associated sheet that the RN signs for each quarter. The nurse had signed that sheet (see: attached), however, the RN has been instructed to insure that she routinely signs the quarterly review document itself...12-2-08. The QMRP will review the medical records monthly to insure routine compliance...12-1-08. The DON will also audit the medical records periodically...12-1-08.	

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W 114	Continued From page 3 signed.	W 114		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that systems were implemented to ensure clients were not subjected to verbal, physical, psychological abuse and mistreatment [See W127]; the facility failed to ensure each clients clothing were of the appropriate size [See W137]; the facility failed to notify parents or guardians of significant incidents [See W148]; the facility's direct care staff failed to implement it's incident management policy [See W149]; the facility failed to ensure that all injurious of unknown source were immediately reported to the administrator or to other officials in accordance with State law [See W153]; and the facility failed to provide evidence that all incidents involving injuries of unknown origin had been thoroughly investigated [See W154] The effects of these systemic practices resulted in the failure of the facility to protect its clients from actual and potential harm and to ensure client's general safety and well being.	W 122	W122 The Client Protections condition issues have been addressed as evidenced by the responses for W127, W137, W148, W149, W153 and W154.	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of	W 124		

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W 124	Continued From page 4 treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for the one of the two clients included in the sample. (Client #2) The finding includes: The facility failed to ensure that informed consent was obtained from Client #2 and/or her legal guardian prior to the administration of her psychotropic medications. Observation of the morning medication administration on October 29, 2008, at 8:48 AM revealed Client #2 was administered Prozac HCL 40 mg, Naltrexone Hydrochlonde 50 mg and Megestrol Acetate 10 ml. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's hand sucking behavior. During the entrance conference on October 294, 2008, an interview was conducted with the Qualified Mental Retardation Professional (QMRP) and House Manager that revealed Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on October 30, 2008, at 3:30 PM through review of Client #1's psychological assessment	W 124	W124 Client #2's legal guardian (mother) did sign consents for the psychotropic drug regimen and the behavior support plan on 12-7-07 (See: attached copies)...12-2-08. MTS will utilize the new standard DDA forms to review and update Client #2's mother on the psychotropic drug regimen and BSP...12-15-08. Thereafter, MTS will insure that a risks/benefits discussion is held and consent is obtained for any changes in the psychotropic drug regimen or the BSP...12-15-08.	

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W 124	Continued From page 5 dated June 13, 2008. According to the assessment, Client #2 "is not able to make independent decisions concerning her residential or day placements. She lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give her informed consent. She lacks the judgment and insight required to make decisions independently." The QMRP further revealed the client had active family involvement to assist her in decision making. Review of the client's medical record and additional interview with the QMRP on October 30, 2008, at 3:06 PM failed to provide evidence that Client #2's treatment needs, including the benefits and potential side effects associated with her medications, and the right to refuse treatment, had been explained to her and a legally authorized representative.	W 124		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to ensure that systems were implemented to ensure clients were not subjected to verbal, physical, and psychological abuse and mistreatment for two of the four clients, residing in the facility. (Clients #2 and #3) The findings include:	W 127	W127 a. The staff member that inappropriately attempted to force feed client #3 was terminated based on the internal investigation findings... 12-2-08.	

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W 127	Continued From page 6 A. On October 29, 2008 at 7:18 AM during breakfast observations, Direct Care Staff (DCS) #13 was observed forcefully feeding and talking harshly to Client #3. DCS #13 was observed standing with her body next to the client's head and shoulder. At the same time, DCS #13's right arm was wrapped over the client's head and her hand was under the client's chin (head lock position). DCS #13 was overheard saying to Client #3, "Eat, I don't have all day, I have a lot to do today." At 7:30 AM, DCS #13 indicated to the surveyor that Client #3 was very difficult to feed. At 7:31 AM, DCS #13 said to Client #3, "Open your mouth you know you like the food." DCS #13 was then observed forcefully sticking the spoon into the client mouth. B. On October 29, 2008 at 7:15 AM, Client #2 was observed independently eating eggs. After completing her eggs, the client stopped eating. DCS #13 verbally prompted Client #2 to eat several times but the client refused and was observed to place her hand into her mouth (hand mouthing). At 7:42 AM, DCS #13 attempted to feed Client #2. The client was observed to refuse by turning her head away from the spoon. At 7:46 AM, DCS #13 attempted to feed the client. Again the client refused. At 7:48 AM, DCS #13 was observed putting the client's food down the drain. DCS #13 then provided the client with a bottle of Boost Plus in a spout cup. At the time of the aforementioned observations, DCS #10 was present at the dining room table feeding Client #4. DCS #5 was in the facility and within hearing distance of the incident. During the entrance conference on October 29, 2008 at 9:20 AM, the Qualified Mental	W 127	The two other staff members on duty at the time were retrained on reporting and addressing abuse/neglect and other serious reportable incident situations before returning to duty...12-2-08. It should be noted that both the QMRP and the Facility Manager observe meal implementation on a routine basis and both report that they have never seen such behavior from the staff member terminated nor any other staff. It should also be noted that the two staff members on duty stated during their investigation interviews that neither had ever seen the terminated staff member or any other staff member provide such inappropriate "assistance" during meals. The QMRP and Facility Manage will continue to observe meals for all shifts at minimum once weekly each and will provide on the spot training when staff fail to follow established protocols...12-15-08. In addition, the in-home staff orientation will be modified to insure that mealtime protocols are trained during the orientation...12-15-08. b. Client #2 has a mealtime protocol that address her support needs when eating but not her periodic tendency to refuse some or all of the food presented to her. As indicated by the surveyor, client #2 ate her eggs and then refused the remainder of the meal. As also mentioned by the surveyor, client #2 began the meal at 7:15am, staff attempted to assist her several times but was refused and at 7:48am, 33 minutes after client #2 started the meal, the staff member discarded the remainder of the meal. Client #2's mealtime protocol will be revised to add instructions on how staff is to address refusals to eat certain portions of a meal or an entire meal. The QMRP, RN and Facility Manager all indicated during the review of this deficiency report that this is not a frequent behavior but rather an infrequent one. Client #2 usually eats well.	

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W 127	Continued From page 7 Retardation Professional (QMRP) and House Manager were informed of the surveyor's observation. At 4:00 PM, the QMRP informed the surveyor's that DCS #13 was placed on administrative leave pending the outcome of the investigation. At 4:32 PM, the facility was notified that the client's health and safety was at risk and an immediate jeopardy existed. At 5:00 PM, the facility implemented a plan of correction to lift the immediate jeopardy. The plan consisted of the following: - the alleged abuser was placed on administrative leaving pending the outcome of an investigation; - the two additional staff that witnessed the alleged abuse were placed on administrative leave pending the outcome of an investigation; and - all remaining staff will be in-serviced by October 31, 2008 on abuse and neglect, incident reporting, mealtime protocols, and Client #2's Behavior Support Plan (BSP). [It should be noted that the surveyor remained onsite until the facility put systems in place to remove the immediate jeopardy.]	W 127	The mealtime protocol will be revised by...12-15-08. Staff will be retrained on the revised program by...12-20-08. The revised program will be implemented by...12-27-08. It should also be noted that it is the individual's right to refuse unwanted treatment and that includes an occasional meal or portions of a meal. The protocol will be modified with respect for that right in mind but will provide strategies that maximize the likelihood of getting client #2 to consume her entire meal via positive reinforcement and respecting her right to choose (for example, by not serving her foods that she clearly dislikes)...12-15-08.	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.	W 148		

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W 148	Continued From page 8 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify parents or guardians of significant incidents for one of the five clients residing in the facility. (Client #5) The finding includes: On October 29, 2008 at 9:15 AM, during the entrance conference with the Qualified Mental Retardation Professional (QMRP) revealed that Client #5 had active family involvement. Review of the facility's unusual incident reports and investigative reports on October 29, 2008 beginning at 10:20 AM, revealed that the facility failed to notify Client #5's family immediately of the following incident: On July 28, 2008, staff discovered swelling on the right side of Client #5's face. Continued review of the facility's incident report however, failed to provide evidence that the client's family had been notified of the aforementioned incident.	W 148	W148 The family of Client #5 was notified about the incident cited here and in fact did visit her in the hospital thereafter. MTS staff failed to indicate the notification on the incident report. The QMRP will review all incident reports before they are submitted to insure that all appropriate notifications occur and are documented. The IMC will provide a second cross check before submission...12-15-08. Staff was retrained on appropriate incident reporting and report development on...10-30-08. The issue will be addressed at minimum quarterly during monthly staff meetings...12-15-08.	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility's direct care staff failed to implement it's incident management policy for two of four clients residing in the facility. (Clients #2 and #3)	W 149	W149 Staff was retrained on incident reporting on 10-30-08 and will be trained at least once per quarter during monthly staff meetings...12-15-08.	

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W 149	Continued From page 9 The finding includes: [Cross Reference W127]. On October 29, 2008 at 7:18 AM during breakfast observations, Direct Care Staff (DCS) #13 was observed forcefully feeding and talking harshly to Client #3. At 7:18 AM, DCS #13 verbally prompted Client #2 to eat several times but the client refused and was observed to place her hand into her mouth (hand mouthing). During At 7:42 AM, DCS #13 attempted to feed Client #2. The client was observed to refused by turning her head away from the spoon. At 7:46 AM, DCS #13 attempted to feed the client. Again the client refused. At 7:48 AM, DCS #13 was observed putting the client's food down the drain. At the time of the aforementioned observations, DCS #10 was present at the dining room table feeding Client #4. DCS #5 was in the facility and within hearing distance of the incident. During the entrance conference on October 29, 2008 at 9:20 AM, the Qualified Mental Retardation Professional (QMRP) and House Manager were informed of the surveyor's observation. At 4:00 PM, the QMRP informed the surveyor's that DCS #13 was placed on administrative leave pending the outcome of the investigation. An interview was conducted with the facility's Qualified Mental Retardation Professional (QMRP) on October 29, 2008 at 9:30 AM, to ascertain if the facility had a written incident management policy. The QMRP provided a policy entitled "Resident Protection" with a revision date of January 30, 2008. Review of that	W 149		

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W 149	Continued From page 10 policy on October 29, 2008 included the following requirements pertaining to abuse, neglect or mistreatment reporting: - report the incident to a supervisor immediately; - follow the instructions given by the supervisor; and - complete an incident report. There was no evidence that the facility's DCS implemented it's incident management policy in a timely manner.	W 149		
W 150	483.420(d)(1)(i) STAFF TREATMENT OF CLIENTS Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to ensure that systems were implemented to ensure clients were free from physical, verbal and psychological abuse for two of the four clients residing in the facility. (Clients #2 and #3) The finding includes: [Cross Reference W127] On October 29, 2008 at 7:18 AM during breakfast observations, Direct Care Staff (DCS) #13 was observed forcefully feeding and talking harshly to Client #3. DCS #13 was also observed attempting to feed Client #2 several times but the client refused. The client was observed to place her hand into her mouth (hand mouthing). After DCS #13's last attempt to	W 150	W150 See responses for W127.	

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W 150	Continued From page 11 feed Client #2 at 7:46 AM, DCS #13 was observed to discard the client's meal by placing it down the drain. At the time of the aforementioned observations, DCS #10 was present at the dining room table feeding Client #4. DCS #5 was in the facility and within hearing distance of the incident. During the entrance conference on October 29, 2008 at 9:20 AM, the Qualified Mental Retardation Professional (QMRP) and House Manager were informed of the surveyor observation. At 4:00 PM, the QMRP informed the surveyor's that DCS #13 was placed on administrative leave pending the outcome of the investigation. At 4:32 PM, the facility was notified that the client's health and safety was at risk and an immediate jeopardy existed. At 5:00 PM, the facility implemented a plan of correction to lift the immediate jeopardy. The plan consisted of the following: - the alleged abuser was placed on administrative leaving pending the outcome of an investigation; - the two additional staff that witnessed the alleged abuse were placed on administrative leave pending the outcome of an investigation; and - all remaining staff will be in-serviced by October 31, 2008 on abuse and neglect, incident reporting, mealtime protocols, and Client #2's Behavior Support Plan (BSP). [It should be noted that the surveyor remained	W 150		

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W 150	Continued From page 12 onsite until the facility put systems in place to remove the immediate jeopardy.]	W 150		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all injurious of unknown source were immediately reported to the administrator or to other officials in accordance with State law, for two of the four clients included in the sample. (Clients #1 and #5) The findings include: 1. Review of the facility's incident reports on October 29, 2008, beginning at 10:20 AM revealed an incident involving Client #5 dated June 9, 2008. According to the report, staff discovered swelling of Client #5's jaw and face. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on October 29, 2008, at 11:00 AM to ascertain information regarding the facility's incident management system. According to the QMRP, all incidents were to be reported to the administrator. Further review of the incident report, however, revealed that there was no documented evidence that indicated the administrator had been notified. At the time of the survey, the facility failed to provide	W 153	W153 1. Executive Director Moore was notified about the June 9, 2008 incident involving client #5 (See: Attached incident report copy)...12-2-08. This is not an incident of unknown origin. Client #5 has a medical condition that causes periodic flare ups of this type (jaw swelling). There is a failure to fully explain this in the nursing notes and QMRP notes (See: attached late entries)...12-2-08. The issue is resolved at present...12-2-08. 2. Client #1's leg bruise is also not of unknown origin. This bruise occurred during the immediately preceding hospitalization as client #1 continuously attempted to get out of bed. Again, there was a failure to fully document this in the nursing notes. The notes mention the bruise without any other details (See: attached late entry notes)...12-2-08. The bruise is resolved at this point...12-2-08. The executive director and Director of Nursing (DON) will reinforce with nursing personnel and the QMRP that their documentation records must fully address such issues routinely...12-15-08. The DON will review the nursing notes periodically to insure they are full and complete and will review the issue routinely during monthly nursing meetings...12-15-08.	

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W 153	Continued From page 13 evidence that ensured the administrator was immediately notified of the incident of unknown origin. 2. Review of Client #1's medical record on October 29, 2008 at approximately 2:00 PM, revealed the following injury of unknown origin was not reported to the Administrator. According to a nursing progress note dated June 19, 2008, staff discovered a bruise on Client #1's left foot below the knee. Further interview and record review revealed no evidence that the injury of unknown origin as reported to the Administrator as required.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that all incidents involving injuries of unknown origin had been thoroughly investigated, for two of the five clients residing in the facility. (Clients #1 and #5) The findings include: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incident reports on October 29 2008 beginning at 10:20 AM revealed the following injuries of unknown origin: a. On June 19, 2008, staff discovered a bruise on Client #1's left foot below the knee. Continued review of the facility's incidents failed to provide	W 154	**W154** **See responses for W153 above.**	

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W 154	Continued From page 14 evidence that the incident had been investigated. b. On June 9, 2008, staff discovered swelling of Client #5's jaw and face. Additionally, there was no evidence the incident had been investigated.	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP), for three of the four clients that resided in the facility. (Clients #1, #2, and #3) The findings include: 1. The facility's QMRP failed to ensure each client received continuous active treatment services. [See W249] 2. The facility's QMRP failed to ensure that data was collected in the form and required frequency. [See W252]	W 159	W159 The issues cited under W159 have been addressed as evidenced by the responses for W249 and W252.	
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by:	W 193		

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W 193	Continued From page 15 Based on observations, staff interview and record verification, the facility's staff failed to demonstrate the skills and techniques necessary to implement each client's Behavior Support Plan (BSP), for one of the two clients in the sample. (Client #1) The finding includes: On October 29, 2008 at 7:10 AM, Client #1 was observed eating eggs for breakfast. During the breakfast observations, the client had mittens/gloves on her hands. At 7:25 AM, the client was observed placing her hands into her mouth (hand mouthing). There was no staff intervention. At 7:53 AM, the client took off the gloves and began sucking her fingers. The direct care staff asked the client to, "please stop." At 7:59 AM, the direct care staff was observed putting the clients mittens/gloves on her hands. Interview with the direct care staff indicated that the client sucks on her hands and fingers, all the time. Record review on October 30, 2008 at approximately 11:00 AM revealed Client #2's BSP dated June 13, 2008. The BSP recommended the following proactive treatment strategies to prevent target behaviors of hand mouthing: - At any time that Client #2 begins to engage in hand mouthing behaviors, verbally prompt her to stop and redirect her to a sensory scheduled activity with one to one supervision. Provide materials or gently body movement. Engage the client for 10-15 minutes. Gently assist the client by taking her hand out of her mouth. Offer her items to hold, and/or place headphones on.	W 193	W193 Staff was retrained on the BSP strategies for client #2...10-30-08. The QMRP and Facility Manager will separately observe active treatment implementation as conducted by each shift at least once weekly and will train staff on the spot when failures to properly implement programs or protocols are noted...12-15-08. In addition, the QMRP will utilize a portion of the monthly staff meeting time at least once per quarter to reinforce the BSP program mandates...12-30-08.	

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W 193	Continued From page 16 - If she continues and is persistent in hand mouthing for 30 minutes place the gloves on her hands and direct her to an activity with physical movement. Remove the gloves after 15 minutes and offer activities again. The aforementioned intervention were not observed being implemented when Client #2 was observed repeatedly hand mouthing. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on October 29, 2008 at 9:20 AM confirmed direct care staff didn't effectively implementing the proactive strategies outlined in Client #2 s BSP. Review of the staff training records on October 30, 2008 at approximately 1:30 PM revealed that all staff signed and received training on Client #2's BSP. There was no evidence that training was successful.	W 193		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure each client received continuous active treatment services, for one of the two clients included in the sample. (Client #1)	W 249		

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W 249	Continued From page 17 The finding includes: Review of Client #1's records on October 30, 2008 at 10:00 AM revealed the client had an Individual Support Plan (ISP) dated July 18, 2008. Interview with the Qualified Mental Retardation Professional (QMRP) on October 30, 2008 at 10:30 AM and further review of Client #1's record revealed that at the time of the ISP meeting, the Interdisciplinary Team (IDT) recommended the following program objectives: a. [the client], will perform lingual strengthening exercises in 10/10 trials to improve bolus formation to prepare for swallowing over three consecutive months; and b. [the client], will perform labial strengthening exercises in 10/10 trials to improve bolus formation to prepare for swallowing over three consecutive months. Interview with the QMRP and review of the client's records on October 30, 2008 at approximately 11:00 AM, there was no evidence that the aforementioned program objectives had been developed, initiated or implemented.	W 249	W249 The protocol needed for the proper implementation of the lingual strengthening and labial strengthening exercises had not been developed by the speech pathologist. They will be completed by...12-4-08. Staff will be trained on the implementation strategies by...12-8-08. The programs will be implemented by...12-20-08. The QMRP was aware of the need to get the programs on line but was having difficulty getting the speech pathologist to provide the needed protocols and data collection systems. In the future, the QMRP will seek the assistance of the Executive Director to move such tasks along in a timelier manner...12-20-08.	
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations interview, and record review, the facility failed to ensure that data was	W 252		

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W 252	Continued From page 18 collected in the form and required frequency, for one of the two clients in the sample. (Client #2) The finding includes: On October 29, 2008 from 4:35 PM until 4:41 PM, staff was observed assisting Client #2 walk throughout the facility. Interview with the direct care staff indicated that the client can walk but had an unsteady gait. Review of the client Individual Program Plan (IPP) dated June 24, 2008 on October 30, 2008 at approximately 11:00 AM revealed an objective which stated, "Given standing assistance, [the client] will ambulate for 15 consecutive minutes five days per week for 12 consecutive months." Review of the data sheet on October 30, 2008 failed to reflect the ambulation on October 29, 2008. There was no evidence that the data had been collected in accordance with the IPP for the client, which was necessary for a functional assessment of the client's progress.	W 252	W252 Staff indeed failed to collect the walking data for client #2 on the survey date but have been consistent otherwise. Staff was retrained to insure future consistency...12-2-08. In addition, the QMRP and Facility Manager will check the data routinely to insure consistency in the data collection...12-2-08.	
W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure each clients Individual Program Plan (IPP) was revised after the client	W 257		

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W 257	Continued From page 19 failed to make progress with the identified objectives, for one of the two clients included in the sample. (Client #2) The finding includes: The QMRP failed to revise Client #2's toothbrushing program as performance measures reflected a lack of progress. The client's documentation and IPP was reviewed on October 30, 2008 at 12:30 PM. The client's IPP reflected the following objective, "[the client] will brush her teeth with 100% efficiency given physical assistance on 30 consecutive occasions." Review of the data collection sheets and the QMRP monthly notes on October 30, 2008 at 1:00 PM revealed that the client had been functioning at the "hand over hand" assistance level since July 2008. Interview with the facility's QMRP at 1:08 PM revealed that the client had always functioned at the "hand over hand " assistance level with regards to this program. There is no evidence that the toothbrushing program had been revised as necessary.	W 257	W257 Client #2 will not improve beyond the hand-over-hand assistance level for the tooth brushing task. The QMRP, RN and Facility Manager agree with this assessment. Tooth brushing will be discontinued as a formal objective and be done as a structured activity. A protocol will be put in place to instruct staff on properly supporting her during the tooth brushing task... 12-20-08.	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for one	W 263		

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W 263	Continued From page 20 of the two included in the sample. (Client #2) The finding includes: Observation of the morning medication administration on October 29, 2008 at 8:48 AM revealed Client #2 received medications including Prozac and Naltrexone. Interview with the medication nurse during the medication administration revealed the aforementioned medication was used to address the client's behavior of hand mouthing. Interview with the Qualified Mental Retardation Profession (QMRP) on October 29, 2008 at 9:20 AM revealed that Client #2 did not have the capacity to give informed consent for the use of her medications and habilitation services. The QMRP's statement was verified on October 30, 2008 at approximately 11:00 AM through review of Client #2's psychological assessment dated June 13, 2008. According to the assessment, Client #2 "does not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters due to profound mental retardation. She can not execute a durable power of attorney." Continued interview with the QMRP on October 30, 2008, further revealed that Client #2 had very involved family involvement. Further review of Client #2's record on October 30, 2008 at 11:00 AM revealed that the client, in addition to taking psychotropic medications, also had a Behavior Support Plan dated June 13, 2008 to address her behavior of hand mouthing. At the time of the survey however, the facility	W 263	W263 As mentioned earlier, signed consent was obtained after a risks/benefits discussion on 12-7-07 for both the BSP and psychotropic drug regimen for client #2...12-2-08. MTS will update the consent documentation using the standard DDA forms for both BSPs and psychotropic drug regimens...12-20-08. In addition, consent will be obtained for any changes in the psychotropic drug regimen or the BSP strategies...12-20-08.	

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W 263	Continued From page 21 failed to provide evidence that consent was obtained for the use of the psychotropic medication and Behavior Support Plan (BSP) that were designed/conducted to reduce Client #2's behaviors. [Cross-refer to W124]	W 263		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, and record review, the facility failed to ensure that each client received all prescribed medications without error for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4) The findings include: 1. Observation of the medication administration on October 29, 2008 at 8:39 AM, revealed Client #4 was administered Vitron C, Multivitamin and Alavert Non-Drowsy. Comparison of the medication administration observation and the physician order dated October 1, 2008 on October 29, 2008 revealed that the client was also prescribed Nasonex Scent Free, two puffs each nostril. Interview with the Licensed Practical Nurse (LPN) on October 29, 2008 at 10:00 AM confirmed that she omitted the client's Nasonex medication. On October 29, 2008 at approximately 10:30 AM, the Registered Nurse (RN) was informed that Client #4 was not administered Nasonex. The RN called the Primary Care Physician (PCP) to inform her of the medication error. The PCP	W 369	W369 1. The nasal spray was given by nursing and the nurse who omitted the medication during her medication pass was retrained on 10-29-08. Client #4 was observed as instructed and showed no ill effects of the delay in receiving the medication...12-2-08. The QMRP, Facility Manager and RN will observe medication passes as implemented by the aforementioned nurse to insure that she routinely passes all medications as prescribed and documents her follow up on the MARs consistently...12-20-08. The RN will review the MTS medication passing guideline with the medication nurse once again and will insure that the guide is available for review routinely...12-20-08. 2. The nurse was delayed another MTS home and failed to notify the RN or DON that she was running late. The clients mentioned were observed and showed no ill effects of receiving their medications slightly outside of the two hour window prescribed by their regimens...12-2-08. The medication nurse was retrained on the MTS medication pass policies...12-2-08.	

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W 369	Continued From page 22 instructed the RN to go to Client #4's day program and administer the client's medication. According to the RN, she administered Client #4's Nasonex at approximately 11:45 AM. 2. On October 29, 2008 at 8:08 AM, the medication nurse arrived in the facility to administer Client #1, #2, #3, and #4's, medications. Review of the physician orders dated October 1, 2008 revealed that the medications are to be administered at 7:00 AM. The first dose of medication was administered to Client #3 at 8:29 AM and the last medication was administered to Client #2 at 8:48 AM. The medication was not within the allotted time frame of one hour before or one hour after the prescribed time. On October 29, 2008 at approximately 10:30 AM, the RN was informed of the medication administration time. The RN called the Primary Care Physician (PCP) to inform her of the medication error. According to the RN, the PCP instructed the RN to monitor Client s#1, #2, #3, and #4 affect.	W 369		
W 392	483.460(m)(3) DRUG LABELING Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to immediately remove discontinued medication from the clients current medication supply, for one of the two	W 392	W392 MTS' medication disposal policy must be revised to eliminate the instruction to flush such medications. The pharmacy does not take back controlled medications. MTS policy will be revised to instruct nurses to crush and sprinkle such medications and discard them in the trash in that form. This plus properly documenting the actions will be the MTS practice going forward...12-15-08.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 392	Continued From page 23 clients included in the sample. (Client #1) The finding includes: Inspection of the medication supply cabinet on October 29, 2008 at 9:10 AM, revealed a medication package of Klonopin 0.5 mg, 30 tablets for Client #1. Interview with the medication nurse at 9:15 AM indicated that the medication was discontinued around August 2008. Further interview indicated that the medication should have been returned to the pharmacy. Record verification on October 29, 2008 at 10:15 AM revealed a physician order dated August 24, 2008, to "Stop Klonopin." However, the medication was still stored in the medication cabinet as of October 29, 2008.	W 392		

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I 000	INITIAL COMMENTS A licensure survey was conducted from October 29, 2008 through October 31, 2008. The fundamental survey process was initiated however due to concerns in Client Protections and Active Treatment, the survey was extended in those areas. A random sample of two residents was selected from a residential population of three females and one male with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews and a review of records, including unusual incident reports. On October 29, 2008, a determination was made that staff's conduct towards Residents #2 and #3 during breakfast posed an immediate and serious threat to their health and safety. At 4:32 PM, the facility's Qualified Mental Retardation Professional (QMRP) and Program Director were notified that an immediate jeopardy existed. The surveyor remained on site until the facility addressed the immediate jeopardy by implementing the following plan to alleviate the identified concerns and protect the resident's from further potential harm: - the alleged abuser was placed on administrative leaving pending the outcome of an investigation; - the two additional staff that witnessed the alleged abuse were placed on administrative leave pending the outcome of an investigation; and - all remaining staff will be in-serviced by October 31, 2008 on abuse and neglect, incident reporting, mealtime protocols, and Client #2's	I 000		

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I 000	Continued From page 1 Behavior Support Plan (BSP). As a result of the findings, a determination was made that the facility failed be in compliance with the Condition of Participation requirements in Client Protection.	I 000		
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure that the modified diet for residents had been reviewed at least quarterly by the consulting dietitian for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. Review of Resident #1's nutritional assessment dated July 18, 2008 on October 29, 2008 at approximately 2:15 PM revealed that the resident was prescribed a regular pureed diet with snacks daily and high fiber. Further review failed to show evidence that the facility's Nutritionist had reviewed Resident #1's diet on a quarterly basis. Record verification of the facility's ISP meeting schedule on October 31, 2008 at 9:15 AM revealed that the client's first quarterly review was scheduled for October 18, 2008. At the time of the survey, the GHMRP failed to have a nutrition quarterly review. 2. On October 29, 2008 at 7:15 AM, Resident #2 was observed eating pureed eggs for breakfast. The resident was also observed drinking a bottle	I 043	**Chapter 35** **3502.2©** **The nutrition quarterly has been completed...12-2-08. The QMRP will audit all discipline notes monthly to insure that all outstanding tasks are completed in a timely manner...12-20-08.**	

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I 043	Continued From page 2 of Boost Plus. Review of Resident #2's nutritional assessment dated June 19, 2008 on October 30, 2008 at approximately 10:00 AM revealed that the resident was prescribed a regular pureed double portion high fiber diet with snacks and one can of Boost Plus, twice per day. Further review failed to show evidence that the facility's Nutritionist had reviewed Resident #2's diet on a quarterly basis. Record verification of the facility's ISP meeting schedule on October 31, 2008 at 9:15 AM revealed that the client's first quarterly review was scheduled for September 24, 2008. At the time of the survey, the GHMRP failed to have a nutrition quarterly review.	I 043		
I 058	3502.16 MEAL SERVICE / DINING AREAS A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observations, staff interview and record verification, the GHMRP failed to ensure that the consulting dietitian conducted at least quarterly reviews for residents on modified diets for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. Review of Resident #1's nutritional assessment dated July 18, 2008 on October 29, 2008 at approximately 2:15 PM revealed that the resident was prescribed a regular pureed diet with snacks daily and high fiber. Further review	I 058	3502.16 See responses for 3502.2 © above	

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I 058	Continued From page 3 failed to show evidence that the facility's Nutritionist had reviewed Resident #1's diet on a quarterly basis. 2. On October 29, 2008 at 7:15 AM, Resident #2 was observed eating pureed eggs for breakfast. The resident was also observed drinking a bottle of Boost Plus. Review of Resident #2's nutritional assessment dated June 19, 2008 on October 30, 2008 at approximately 10:00 AM revealed that the resident was prescribed a regular pureed double portion high fiber diet with snacks and one can of Boost Plus, twice per day. Further review failed to show evidence that the facility's Nutritionist had reviewed Resident #2's diet on a quarterly basis.	I 058		
I 167	3507.4(e) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (e) Personnel, which covers job descriptions and qualifications, staff/resident ratios, training and staff development, health inventory; This Statute is not met as evidenced by: Based on review of records the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that their Policies and Procedures' Manual included a personnel policy that addressed job descriptions and qualifications, staff/resident ratios, training and staff development, and health inventories The finding includes: Review of the policies and procedures on October 30, 2008, failed to provide evidence of a personnel policy that addressed job descriptions	I 167	3507.4(c) Existing MTS policies address job descriptions, qualifications, staff/resident ratios, training and health certificates (see: attachments)...12-2-08. However, MTS is in the process of developing a new personnel policy manual that should be completed by...2-1-08.	

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I 167	Continued From page 4 and qualifications, staff/resident ratios, training and staff development, health inventories.	I 167		
I 185	3508.5(b) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (b) The personnel in charge of the program components; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have an organization chart the showed the personnel in charge of the program components. The finding includes: Review of the GHMRP's administrative records on October 30, 2008 at 1:00 PM, revealed that the organization chart failed to identify the personnel in charge of the program components.	I 185	**3508.5(b) and 3508(c)** **See the attached copies of MTS organizational charts... 12-2-08.**	
I 186	3508.5(c) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (c) The categories and numbers of supportive and direct care staff; and,.. This Statute is not met as evidenced by: Based on review of the policy and procedures manual and request of management staff, the GHMRP failed to provide an organizational chart depicting categories and numbers of supportive and direct care staff. The finding includes:	I 186		

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I 186	Continued From page 5 Review of the GHMRP's administrative records on October 30, 2008 at 1:00 PM, revealed that the organization chart failed to list the categories and numbers of supportive and direct care staff.	I 186		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees. The findings include: Review of the personnel files conducted on October 31, 2008 at approximately 11:00 AM, revealed the GHMRP failed to provide evidence that the facility discussed the contents of job description with staff. It should be noted that the present recorded did not include a job description for Staff #2, #6, #11,and #12.	I 203	**3509.3** **Job description updates have been completed for the staff cited (see: attached copies)...12-2-08.** **The Facility Manager perform quarterly audits in order to track due dates and insure routine updates...12-20-08.**	
I 224	3510.5(a) STAFF TRAINING Each training program shall include, but not be limited to, the following: (a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, associated health implications, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills;	I 224	**3510.5(a) and (b)** **Introduction to mental retardation and Human Development are covered in the MTS staff orientation but the QMRP will conduct a training session for all staff by...12-20-08.**	

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I 224	Continued From page 6 This Statute is not met as evidenced by: Based on record review, the GHMRP failed to include training in overview of mental retardation to each staff. The finding includes: Review of the training records on Ocotber 30, 2008, revealed that the GHMRP failed to provide training in overview of mental retardation.	I 224		
I 225	3510.5(b) STAFF TRAINING Each training program shall include, but not be limited to, the following: (b) Human development through the life cycle (birth to death); This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure training was provided to each staff in the area of Human Development. The finding includes: Review of the training records on October 30, 2008 revealed that the GHMRP failed to provide training in Human Development.	I 225		
I 232	3510.5(i) STAFF TRAINING Each training program shall include, but not be limited to, the following: (i) Training of the residents in the maintenance of oral health and hygiene. This Statute is not met as evidenced by:	I 232	**3510.5(i)** **Dental (oral health and hygiene) was completed (see attached copy of signature sheet) but will be done again by...12-20-08.** **The QMRP will develop a January through June 2009 schedule outlining all required trainings and their implementation timelines...12-30-08.** **The schedule will be modified and repeated for July through December 2009.**	

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I 232	Continued From page 7 Based on record review, the GHMRP failed to ensure training was provided to each staff in the ara of oral and health hygiene. The finding includes: Review of the training records on October 30, 2008 revealed that the GHMRP failed to provide training in oral health and hygiene.	I 232		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure each residents records were kept current, dated and signed by each individual that made an entry, for two of the two residents in the sample. (Residents #1 and #2) The findingd include: The facility's Registered Nurse (RN) failed to sign Residents #1 and #2's quarterly reviews. a. Interview with the facility's Registered Nurse on October 29, 2008 at approximately 3:00 PM revealed that she (RN) completed quarterly nursing examinations. Review of the Resident #1's medical record revealed a nursing quarterly review dated October 22, 2008 that was not signed. b. Interview with the facility's Registered Nurse on October 30, 2008 at approximately 11:00 AM revealed that she (RN) completed quarterly nursing examinations. Review of the Resident #2's medical record revealed a nursing quarterly	I 291	The RN has placed a post-dated signature on the cited quarterly nursing examinations. There is an associated sheet that the RN signs for each quarter. The nurse had signed that sheet (see: attached), however, the RN has been instructed to insure that she routinely signs the quarterly review document itself...12-2-08. The QMRP will review the medical records monthly to insure routine compliance...12-1-08. The DON will also audit the medical records periodically...12-1-08.	

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I 291	Continued From page 8 review dated August 18, 2008 that was not signed.	I 291		
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) one of the five residents in the sample. (Resident #5) The finding includes: On October 29, 2008 at 9:15 AM, during the entrance conference with the Qualified Mental Retardation Professional (QMRP) revealed that Resident #5 had active family involvement. Review of the facility's unusual incident reports and investigative reports on October 29, 2008 beginning at 10:20 AM, revealed that the facility failed to notify Resident #5's family immediately of the following incident: On July 28, 2008, staff discovered swelling on the right side of Resident #5's face. Continued review of the facility's incident report however, failed to provide evidence that the	I 374	The family of Client #5 was notified about the incident cited here and in fact did visit her in the hospital thereafter. MTS staff failed to indicate the notification on the incident report. The QMRP will review all incident reports before they are submitted to insure that all appropriate notifications occur and are documented. The IMC will provide a second cross check before submission...12-15-08.	

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I 374	Continued From page 9 resident's family had been notified of the aforementioned incident.	I 374		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that injuries of unknown origin are reported to the facility's administrator and government agencies as required by DC Regulation [22 DCMR Chapter 35 Section 3919.10]. The findings include: 1. Review of the facility's incident reports on October 29, 2008, beginning at 10:20 AM revealed an incident involving Resident #5 dated June 9, 2008. According to the report, staff discovered swelling of Resident #5's jaw and face. 2. Review of the Resident #1's medical record on October 29, 2008 at approximately 2:00 PM, revealed the following injury of unknown origin. According to a nursing progress note dated June	I 379	Staff was retrained on incident reporting on 10-30-08 and will be trained at least once per quarter during monthly staff meetings...12-15-08.	

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I 379	Continued From page 10 19, 2008 revealed that staff discovered a bruise on Resident #1's left foot below the knee. Further interview and record review revealed no evidence that the injury of unknown origin as reported to the Department of Health as required.	I 379		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide training and assistance to residents in accordance with the their Individual Habilitation Plans for one of the two residents included in the sample. (Resident #1) The findings include: Review of Resident #1's records on October 30, 2008 at 10:00 AM revealed the resident had an Individual Support Plan (ISP) dated July 18, 2008. Interview with the Qualified Mental Retardation Professional (QMRP) on October 30, 2008 at 10:30 AM and further review of Resident #1's record revealed at the time of the ISP meeting, the Interdisciplinary Team (IDT) recommended the following program objectives: a. [the resident], will perform lingual strengthening exercises in 10/10 trials to improve bolus formation to prepare for swallowing over three consecutive months; and b. [the resident], will perform labial strengthening exercises in 10/10 trials to improve bolus formation to prepare for swallowing over three consecutive months.	I 422	**The protocol needed for the proper implementation of the lingual strengthening and labial strengthening exercises had not been developed by the speech pathologist. They will be completed by...12-4-08.** **Staff will be trained on the implementation strategies by...12-8-08.** **The programs will be implemented by...12-20-08.** **The QMRP was aware of the need to get the programs on line but was having difficulty getting the speech pathologist to provide the needed protocols and data collection systems. In the future, the QMRP will seek the assistance of the Executive Director to move such tasks along in a timelier manner...12-20-08.**	

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I 422	Continued From page 11 Interview with the QMRP and review of the resident's records on October 30, 2008 at approximately 11:00 AM, there was no evidence that the aforementioned program objectives had been developed, initiated or implemented.	I 422		
I 430	3521.7(a) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to train residents to develop strengthening exercises to improve bolus formation in prepariong for swallowing, for one of the two residents in the sample. (Resident #1) The findings include: Review of Resident #1's records on October 30, 2008 at 10:00 AM revealed the resident had an Individual Support Plan (ISP) dated July 18, 2008. Interview with the Qualified Mental Retardation Professional (QMRP) on October 30, 2008 at 10:30 AM and further review of Resident #1's record revealed that at the time of the ISP meeting, the Interdisciplinary Team (IDT) recommended the following program objectives: a. [the resident], will perform lingual strengthening exercises in 10/10 trials to improve bolus formation to prepare for swallowing over	I 430	The protocol needed for the proper implementation of the lingual strengthening and labial strengthening exercises had not been developed by the speech pathologist. They will be completed by...12-4-08. Staff will be trained on the implementation strategies by...12-8-08. The programs will be implemented by...12-20-08. The QMRP was aware of the need to get the programs on line but was having difficulty getting the speech pathologist to provide the needed protocols and data collection systems. In the future, the QMRP will seek the assistance of the Executive Director to move such tasks along in a timelier manner...12-20-08.	

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	HFD03-0181	A. BUILDING _____ B. WING _____	10/31/2008

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I 430	Continued From page 12 three consecutive months; and b. [the resident], will perform labial strengthening exercises in 10/10 trials to improve bolus formation to prepare for swallowing over three consecutive months. According to the QMRP and review of the resident's records failed to provide evidence that the aforementioned program objectives had been developed, initiated or implemented.	I 430		
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to promptly destroy prescribed medication that was discontinued by the primary care physician for one of the two residents included in the sample. (Resident #1) The finding includes: Inspection of the medication supply cabinet on October 29, 2008 at 9:10 AM, revealed a medication package of Klonopin 0.5 mg, 30 tablets for Resident #1. Interview with the medication nurse at 9:15 AM indicated that the medication was discontinued around August 2008. Further interview indicated that the medication should have been returned to the pharmacy. Record verification on October 29, 2008 at 10:15 AM revealed a physician order dated August 24, 2008, to "Stop Klonopin." However, the medication was still stored in the	I 484	**MTS' medication disposal policy must be revised to eliminate the instruction to flush such medications. The pharmacy does not take back controlled medications. MTS' policy will be revised to instruct nurses to crush and sprinkle such medications and discard them in the trash in that form. This plus properly documenting the actions will be the MTS practice going forward...12-15-08.**	

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I 484	Continued From page 13 medication cabinet as of October 29, 2008.	I 484		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that systems were designed and implemented to ensure clients were not subjected to verbal, physical and psycholgoical abuse and mistreatment, for two of the five residents that resided in the facility. (Residents #2 and #3) The findings include: 1. On October 29, 2008 at 7:18 AM during breakfast observations, Direct Care Staff (DCS) #13 was observed forcefully feeding and talking harshly to Client #3. DCS #13 was observed standing with her body next to the client's head and shoulder. At the same time, DCS #13's right arm was wrapped over the client's head and her hand was under the client's chin (head lock position). DCS #13 was overheard saying to Client #3, "Eat, I don't have all day, I have a lot to do today." At 7:30 AM, DCS #13 indicated to the surveyor that Client #3 was very difficult to feed. At 7:31 AM, DCS #13 said to Client #3, "Open your mouth you know you like the food." DCS #13 was then observed forcefully sticking the spoon into the client mouth. 2. On October 29, 2008 at 7:15 AM, Client #2 was observed independently eating eggs. After	I 500	The staff member that inappropriately attempted to force feed client #3 was terminated based on the internal investigation findings...12-2-08.	

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I 500	Continued From page 14 completing her eggs, the client stopped eating. DCS #13 verbally prompted Client #2 to ear several times but the client refused and ws observed to place her hand into her mouth (hand mouthing). At 7:42 AM, DCS #13 attempted to feed Client #2. The client was observed to refused by turning her head away from the spoon. At 7:46 AM, DCS #13 attempted to feed the client. Again the client refused. At 7:48 AM, DCS #13 was observed putting the client's food down the drain. DCS #13 then provided the client with a bottle of Boost Plus in a spout cup. At the time of the aforementioned observations, DCS #10 was present at the dining room table feeding Client #4. DCS #5 was in the facility and within hearing distance of the incident. During the entrance conference on October 29, 2008 at 9:20 AM, the Qualified Mental Retardation Professional (QMRP) and House Manager were informed of the surveyor observation. At 4:00 PM, the QMRP informed the surveyor's that DCS #13 was placed on administrative leave pending the outcome of the investigation. At 4:32 PM, the facility was notified that the client's health and safety was at risk and an immediate jeopardy existed. At 5:00 PM, the facility implemented a plan of correction to lift the immediate jeopardy. The plan consisted of the following: - the alleged abuser was placed on administrative leaving pending the outcome of an investigation; - the two additional staff that witnessed the alleged abuse were placed on administrative leave pending the outcome of an investigation;	I 500	The two other staff members on duty at the time were retrained on reporting and addressing abuse/neglect and other serious reportable incident situations before returning to duty...12-2-08. It should be noted that both the QMRP and the Facility Manager observe meal implementation on a routine basis and both report that they have never seen such behavior from the staff member terminated nor any other staff. It should also be noted that the two staff members on duty stated during their investigation interviews that neither had ever seen the terminated staff member or any other staff member provide such inappropriate "assistance" during meals. The QMRP and Facility Manage will continue to observe meals for all shifts at minimum once weekly each and will provide on the spot training when staff fail to follow established protocols...12-15-08. In addition, the in-home staff orientation will be modified to insure that mealtime protocols are trained during the orientation...12-15-08. b. Client #2 has a mealtime protocol that address her support needs when eating but not her periodic tendency to refuse some or all of the food presented to her. As indicated by the surveyor, client #2 ate her eggs and then refused the remainder of the meal. As also mentioned by the surveyor, client #2 began the meal at 7:15am, staff attempted to assist her several times but was refused and at 7:48am, 33 minutes after client #2 started the meal, the staff member discarded the remainder of the meal. Client #2's mealtime protocol will be revised to add instructions on how staff is to address refusals to eat certain portions of a meal or an entire meal. The QMRP, RN and Facility Manager all indicated during the review of this deficiency report that this is not a frequent behavior but rather an infrequent one. Client #2 usually eats well.	

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I 500	Continued From page 15 and - all remaining staff will be in-serviced by October 31, 2008 on abuse and neglect, incident reporting, mealtime protocols, and Client #2's Behavior Support Plan (BSP). [It should be noted that the surveyor remained onsite until the facility put systems in place to remove the immediate jeopardy.] 3. The facility failed to ensure that informed consent was obtained from Client #2 and/or her legal guardian prior to the administration of her psychotropic medications. Observation of the morning medication administration on October 29, 2008, at 8:48 AM revealed Client #2 was administered Prozac HCL 40 mg, Naltrexone Hydrochlonde 50 mg and Megestrol Acetate 10 ml. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's hand sucking behavior. During the entrance conference on October 294, 2008, an interview was conducted with the Qualified Mental Retardation Professional (QMRP) and House Manager that revealed Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on October 30, 2008, at 3:30 PM through review of Client #1's psychological assessment dated June 13, 2008. According to the assessment, Client #2 "is not able to make independent decisions concerning her residential or day placements. She lacks the cognitive skills necessary to understand the implications of such	I 500	The mealtime protocol will be revised by...12-15-08. Staff will be retrained on the revised program by...12-20-08. The revised program will be implemented by...12-27-08. It should also be noted that it is the individual's right to refuse unwanted treatment and that includes an occasional meal or portions of a meal. The protocol will be modified with respect for that right in mind but will provide strategies that maximize the likelihood of getting client #2 to consume her entire meal via positive reinforcement and respecting her right to choose (for example, by not serving her foods that she clearly dislikes)...12-15-08. Client #2's legal guardian (mother) did sign consents for the psychotropic drug regimen and the behavior support plan on 12-7-07 (See attached copies)...12-2-08. MTS will utilize the new standard DDA forms to review and update Client #2's mother on the psychotropic drug regimen and BSP...12-15-08. Thereafter, MTS will insure that a risks/benefits discussion is held and consent is obtained for any changes in the psychotropic drug regimen or the BSP...12-15-08.	

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I 500	Continued From page 16 decisions and therefore cannot give her informed consent. She lacks the judgment and insight required to make decisions independently." The QMRP further revealed the client had active family involvement to assist her in decision making. Review of the client's medical record and additional interview with the QMRP on October 30, 2008, at 3:06 PM failed to provide evidence that Client #2's treatment needs, including the benefits and potential side effects associated with her medications, and the right to refuse treatment, had been explained to her and a legally authorized representative.	I 500		